

IN THE MATTER OF

JOHN I. TIFFORD, D.D.S.

Respondent

License Number: 4853

* BEFORE THE MARYLAND

* STATE BOARD OF

* DENTAL EXAMINERS

* Case Number: 2013-115

* * * * *

CONSENT ORDER

On July 3, 2013, the Maryland State Board of Dental Examiners (the "Board") charged **JOHN I. TIFFORD, D.D.S.**, License Number 4853 (the "Respondent") with violating the Maryland Dentistry Act (the "Act"), codified at Md. Code Ann., Health Occ. ("Health Occ."), §§ 4-101 *et seq.* (2009 Repl. Vol.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. § 4-315:

- (a) *License to practice dentistry* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may... reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if... the licensee:
 - (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
 - (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]
 - (28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's guidelines on universal precautions[.]

On September 4, 2013, a Case Resolution Conference was held before a panel of the Board. As a resolution of this matter, the Respondent agreed to enter into this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice dentistry in Maryland on July 14, 1970, under License Number 4853.

2. At all times relevant hereto, the Respondent maintained an office for the practice of dentistry at 3601 Leonardtown Road, Waldorf, Maryland 20604.

3. The Board initiated an investigation of the Respondent after receiving a complaint on or about December 19, 2012, from a former patient ("Patient A")¹ of the Respondent, who stated that she had denture work done by the Respondent between September 2011 and August 2012. Patient A alleged that during that time, she contracted a fungal infection in her mouth as a result of the unsanitary conditions in the Respondent's office.

4. In the course of its investigation, the Board retained an independent consultant (the "Board Expert"), who conducted an inspection of the Respondent's dental office on April 4 and April 9, 2013, to determine whether the Respondent's practice was in compliance with the Center for Disease Control and Prevention ("CDC") Guidelines for Infection Control in Dental-Health Settings (the "CDC Guidelines"). During the inspections, the Board Expert noted no staff personnel in the Respondent's office. The Respondent explained that he had been without staff personnel for the past

¹ To ensure confidentiality, the names of individuals, hospitals and healthcare facilities involved in this case, other than the Respondent, are not disclosed in this document.

two weeks and was in the process of hiring them. In a report dated May 9, 2013, the Board Expert provided her findings to the Board.

5. Board investigation determined that the Respondent's dental practice failed to comply with numerous CDC Guidelines, including, but not limited to: failing to follow the protocols for an in-office spore testing program; failing to maintain dental office in a clean, organized, sanitary and safe condition; failing to secure and dispose contaminated gloves in a proper manner; failing to properly secure and timely process potentially contaminated instruments; failing to dispose waste and sharps in a proper and timely manner; and failing to maintain adequate records relating to the office's Health and Safety Program and Infection Control Program.

BOARD INSPECTION

Office Description

6. The Respondent's dental office is the sole occupant of a freestanding building. The Board Expert when conducting her inspection, noted that although the Respondent's reception area, patient bathroom and clinic hallway were clean and well maintained, his treatment rooms, dental laboratory and sterilization area were cluttered with equipment, supplies and used instruments, which prevented access for cleaning and disinfection.

Written Protocol, Recordkeeping and Posters

7. When requested, the Respondent was unable to provide adequate documentation of written protocols and records for the past three years relating to his office's Health and Safety Program, including the exposure control plan, initial and

annual employee training, employee Hepatitis B vaccination records and employee post-exposure forms.

8. The Respondent was also unable to provide adequate documentation of written safety protocols, including those relating to post-exposure protocol, equipment disinfection protocol and instrument sterilization protocol.

9. The Board Expert further observed that the Respondent did not post Board mandated "We Take Precautions for You" poster in his office.

Standard Precautions and Personal Protective Equipment

10. During her inspection, the Board Expert observed the Respondent failed to wash his hands even once despite donning and removing treatment and utility gloves on multiple occasions. When the Respondent removed his treatment gloves, he placed them in his coat pocket rather than discard them. On one occasion when the Respondent removed his utility gloves after handling contaminated instruments, he placed the gloves on what he designated as the clean side of the sterilization area.

11. The Board Expert also observed soiled jackets on the kitchen table in the staff kitchen. Additionally, although an eyewash station was available in the sterilization sink, the safety caps were missing and chemical splashes and debris were visible on the screens.

Sterilization Protocol

12. In the course of her inspection, the Board Expert observed numerous instruments such as dental hand-pieces, hand instruments and burs left on bracket trays without verification that they had been sterilized. The Board Expert also observed bagged and unbagged dental hand-pieces commingled in same equipment drawers.

13. When inspecting the sterilization area, the Board Expert observed a backlog of instruments that were piled on cassette trays and autoclave baskets. The trays and baskets were precariously placed on equipment and counters. When inspecting the equipment drawers, the Board Expert found instruments that were not bagged.

14. During the inspection the Board Expert requested the Respondent demonstrate the debridement of instruments. Instead of using a strainer baskets or a forceps, the Respondent used his hands to retrieve instruments directly from the ultrasonic bath and chemical bin. When demonstrating use of the automatic cleaner, the Respondent struggled to turn on and operate the machine.

15. When demonstrating spore testing, the Respondent failed to place a control in the incubator as required and was not even aware that the machine was not turned on after placing the test capsule. When asked to provide weekly spore testing records, the Respondent was unable to provide any record for 2012 and 2013.

Sterilization Area

16. During the inspection, the Respondent was unable to demonstrate distinct clean and dirty areas in the sterilization room. The Board Expert observed processed and unprocessed instruments sharing the same drawer and packaged and unpackaged instruments commingled in what was designated as the clean area of the room.

Treatment Room Disinfection and Cross Contamination Prevention

17. In her inspection of treatment rooms, the Board Expert observed that dental hand-pieces were left on the bracket tray after other patient care items had been removed, and orthodontic instruments were stored on the countertop unbagged. The

Board Expert further noted that a large number of items stored on the countertop in the treatment rooms complicated decontamination after patient care.

18. The Board Expert's inspection of the storage cupboard in the treatment rooms and sterilization area revealed both expired and current dental materials that were commingled.

19. In the staff kitchen, the Board Expert observed dental materials, protective equipment and kitchen items intermingled on the countertop and table.

20. When asked how he transported used instruments to the sterilization area, the Respondent did so by using an instrument cassette as a carrier. The carrier, however, contained holes that presented a risk for exposure incidents.

21. The Respondent also failed to establish a dental unit waterline maintenance policy and failed to perform baseline water testing.

Sharps Management and Regulated/Biohazardous Waste Disposal

22. The Respondent was unable to provide waste manifests documenting proper disposal of medical waste for the past three years. In a response subsequent to the inspection, the Respondent stated that waste and sharps were "Done in office. Office sterilizes or retains sharpies." The Respondent, however, failed to provide any documented protocols for packaging, autoclaving and proper disposal of waste. The Board Expert observed containers of medical waste in the sterilization area that were overfilled.

Laboratory Area

23. The Board Expert observed that countertops in the laboratory were cluttered with equipment, stone casts and supplies, which complicated disinfection.

First Aid and Emergency Procedures

24. The Respondent's dental office had two exits, one by the reception area and the second by the kitchen/staff room. The Board Expert observed that the exit by the kitchen/staff room was blocked with equipment and a metal bar.

25. When asked by the Board Expert, the Respondent was unable to produce a written policy for Managing Occupational Exposure. Documents provided by the Respondent purporting to be post-exposure policies lacked clarity and consistency.

26. The Board Expert also noted that the Respondent's office did not have a CPR resuscitator mask and all the drugs in an emergency kit the Respondent provided were expired.

27. Throughout the Respondent's office, the Board Expert observed numerous expired dental materials stored with current dental materials, including Fluoride (in Room Two), Penicillin-VK, Nu Gauze, PGA absorbable sterile sutures.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent practiced dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of Health Occ. § 4-315(a)(6); behaved dishonorably or unprofessionally, in violation of Health Occ. § 4-315(a)(16); and failed to comply with the Centers for Disease Control's guidelines on universal precautions, for the following reasons:

- A. Failing to maintain generally clean and sanitary condition in his dental office;

- B. failing to maintain adequate written records of employee training for at least the past three years;
- C. failing to maintain adequate Hepatitis B vaccination records of employees;
- D. failing to utilize, secure and dispose of treatment and utility gloves in a proper manner;
- E. failing to maintain safety caps and remove chemical splashes and debris at eyewash stations;
- F. failing to maintain clearly distinct clean and dirty areas in the sterilization room;
- G. failing to perform or document performing office spore testing on a weekly basis during the year 2012 and 2013;
- H. failing to segregate and make distinguishable processed and unprocessed reusable intra-oral instruments;
- I. failing to demonstrate ability to operate the office incubator, autoclaves and disinfecting equipment;
- J. failing to maintain waste manifests for at least three years showing proper disposal of medical waste;
- K. failing to dispose sharps in a proper and timely manner;
- L. failing to maintain generally clean, organized and sanitary conditions in dental laboratory;
- M. failing to have available a CPR resuscitator mask;
- N. failing to discard expired dental materials and drugs; and
- O. failing to address multiple safety hazards, including (1) having equipment blocking one of two exits and; (2) placing potentially contaminated materials on kitchen countertops.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by a majority of the Board considering this case:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland is hereby **SUSPENDED** for a period of **SEVEN (7) DAYS**, to commence on DECEMBER 14, 2013, and continuing until the Respondent has fully and satisfactorily complied with the following terms and conditions:

- (1) The Respondent's dental office shall be subject to an unannounced inspection conducted by a Board-approved inspector, other than the Board expert who conducted the original inspection; and
- (2) If the Respondent passes the inspection, the suspension of his license will be lifted. If the Respondent does not pass the inspection, the suspension of his license will continue until he passes the inspection.

AND IT IS FURTHER ORDERED that as soon as the Respondent passes the inspection by the Board-approved inspector, the Respondent shall be placed **PROBATION** for a minimum period of **ONE (1) YEAR** and until the following terms and conditions are fully and satisfactorily complied with:

- (1) During the probationary period, the Respondent's dental office shall be subject to three (3) unannounced inspections; and
- (2) During the probationary period, the Respondent shall enroll in and successfully complete a six (6) hour Board-approved CDC course. This course will not be counted toward his continuing education requirements for renewal.
- (3) A finding of non-compliance with CDC Guidelines by the inspector may constitute a violation of probation and this Consent Order, and may, in the Board's discretion, be grounds for immediate suspension of the Respondent's license and further disciplinary action under the Act.

AND IT IS FURTHER ORDERED that after the conclusion of the **ONE (1) YEAR** probationary period, the Respondent may submit a written petition to the Board

requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, may grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints relating to violations of CDC Guidelines; and it is further


ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing if there is a genuine dispute as to the underlying facts, or an opportunity for a show cause hearing, before the Board otherwise, may impose any sanction which the Board may have imposed in this case, including probationary terms and conditions, a reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED the Respondent shall practice in accordance with the Maryland Dentistry Act and all applicable laws, statutes and regulations pertaining to the practice of dentistry; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of his probation and this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., State Gov't, §§ 10-611 *et seq.* (2009 Repl. Vol.).

12/09/2013
Date



Ngoc Quang Chu, D.D.S.
President
MD State Board of Dental Examiners

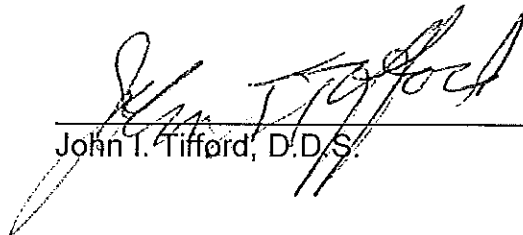
CONSENT

I, John I. Tifford, D.D.S., acknowledge that I had the opportunity to consult with counsel in this matter but freely and voluntarily elected not to do so before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions. I acknowledge the violations as set forth above and accept personal responsibility for my behavior.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

11-29-13
Date



John I. Tifford, D.D.S.

NOTARY

STATE OF

Maryland

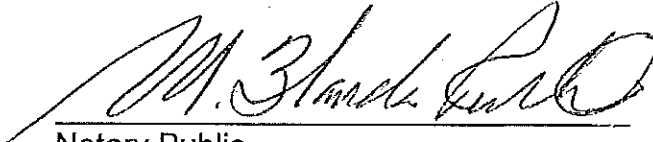
CITY/COUNTY OF

Charles

I HEREBY CERTIFY that on this 29th day of November,

2013, before me, a Notary Public of the foregoing State and City/County personally appear John I. Tifford, D.D.S., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.



Notary Public

My commission expires:

MARY WANDA RUTH
NOTARY PUBLIC
State of Maryland, County of Charles
My Commission Expires October 25, 2015

10-25-15